Truitt S. Boatright, MD
Jessica T. Ford, MD
Lindsay S. Kinnebrew, MD
Lance Slade, MD
Chris J. Cawley, MD
Robert A. Ford, MD
Jane Maddox, MD
Jason Smith, MD
R. Kim Coker, MD
Gabriella R. Kacsoh, MD
Donna Payne, MD
Jill M. Waters, MD

Authorization for Release of Health Information to Primary Pediatrics, P.C.

By signing this form, I authorize the organization named below to use, release, or disclose the protected health information described below to Primary Pediatrics, P.C.

Please transmit via: ☐ Fax, ☐ Mail, ☐ Pick Up
Pick up is not available for medical records (unless it is to get a Social Security card) Cost per child $10

Date of Request: _____

Organization PROVIDING the information:	Organization RECEIVING the information:
Primary Pediatrics, PC 5300 Bowman Road Macon, GA 31210	Name: _____ Address: _____ _____ Fax Number: _____

Purpose of disclosure (i.e. at the request of the patient, parent, guardian, employment, life or disability insurance, etc.):

_____

I authorize the following information to be sent to the address above:

☐ Copies of all medical records for the period ____/____/____ to ____/____/____
☐ Copies of all of the information described below for the period ____/____/____ to ____/____/____
☐ General Paperwork (school, FMLA, etc.)
☐ History & Physical Examination ☐ Lab, Radiology Reports
☐ WIC Form ☐ Sports Physical Form
☐ Report from other physicians ☐ Other (Please specify): _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should NOT be released, even if occurring during the dates above:

_____

Please describe any special requirements such as faxing, certified mail, extended expiration dates, etc.

_____

I understand that Primary Pediatrics, P.C. assumes no responsibility for the use or misuse by others of the health information disclosed under this authorization. I realize the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I release Primary Pediatrics, P.C. from all legal liability that may arise from this authorization. I understand I may revoke this authorization at any time by submitting a written request to the practice.

Child's Name: _____ Date of Birth: _____
Parent/Guardian Name: _____ Relationship (*Required*): _____
Parent/Guardian Signature: _____ Phone Number: _____